STATE OF CALIFORNIA
SUPPLEMENTAL CLAIM
BC-VOC-100 SUP (REV 02/89)

STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM

INSTRUCTIONS

This Supplemental Claim form is used to claim any bills not claimed on your original application or any previous Supplemental Claim. Complete this form and send it with any new bills to your representative (Victim/Witness Center or attorney) or to the Victims of Crime (VOC) Program. Copies of itemized bills and proof of insurance or other payments for these losses MUST be attached.

APPLICANT INFORMATION:

APPLICANT NAME | CLAIM NUMBER

MAILING ADDRESS | CITY | STATE | ZIP

SOCIAL SECURITY NO. | DATE OF BIRTH | IS THIS A NEW ADDRESS? [ ] NO [ ] YES

SUPPLEMENTAL LOSS INFORMATION - CHECK ADDITIONAL LOSSES NOT CLAIMED BEFORE

[ ] MEDICAL [ ] MENTAL HEALTH [ ] FUNERAL/BURIAL [ ] JOB RETRAINING

Copies of itemized bills for these additional losses MUST be attached. Also attach records of all payments from other sources. Unless you object, outstanding balances will be paid directly to the provider.

[ ] INCOME/SUPPORT LOSS: PERIOD NOW BEING CLAIMED _____ TO _____ If not claimed before, complete employer information below:

EMPLOYER NAME | PHONE NUMBER

MAILING ADDRESS | CITY | STATE | ZIP

[ ] NO [ ] YES HAS A DOCTOR GIVEN YOU A DISABILITY STATEMENT?

If yes, attach a copy and complete below (if not previously provided):

DOCTOR'S NAME | PHONE NUMBER

MAILING ADDRESS | CITY | STATE | ZIP

CIVIL SUIT

[ ] NO [ ] YES HAVE YOU FILED A CIVIL SUIT AS A RESULT OF THIS CRIME?

If yes, please write your attorney's name, address and phone number on the back of this form.

DECLARATION - AT LEAST ONE OF THESE STATEMENTS MUST BE SIGNED

APPLICANT

I understand it is my responsibility to inform the Victims of Crime Program of any other reimbursements or sources of reimbursement for these losses. I declare under penalty of perjury under the laws of the State of California that, all losses claimed are directly related to the crime described on my original application.

APPLICANT SIGNATURE | DATE | PHONE NUMBER (daytime)

X

REPRESENTATIVE

I declare that, to the best of my knowledge and belief, the services claimed were provided and the attached bills are directly related to the injury described on this applicant's original application.

REPRESENTATIVE SIGNATURE | DATE | PHONE NUMBER (daytime)

X

PROVIDER

I certify that these services were provided to a minor victim or that every reasonable effort to locate the adult applicant responsible for the attached bill(s) has been made to no avail, the service(s) claimed were provided and the attached bill(s) is to the best of my knowledge and belief, directly related to the injury described on the applicant's original VOC application.

PROVIDER SIGNATURE | DATE | PHONE NUMBER (daytime)

X

GIVE THIS CLAIM TO YOUR REPRESENTATIVE
OR
IF YOU DO NOT HAVE A REPRESENTATIVE, MAIL TO:

STATE BOARD OF CONTROL
VICTIMS OF CRIME PROGRAM
P.O. BOX 942003
SACRAMENTO, CA 94204-2003